

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 9053

County GarrettVillage or City Mar Accident No. 94STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 164

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James C Beachy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

June 30, 1857
(Month) (Day) (Year)

7 AGE

57 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9 BIRTHPLACE (State or country)

Garrett Co Md.

10 NAME OF FATHER

Christian Beachy

11 BIRTHPLACE OF FATHER (State or country)

Garrett Co Md

12 MAIDEN NAME OF MOTHER

Mary Beachy

13 BIRTHPLACE OF MOTHER (State or country)

Garrett Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. C. Beachy

(Address)

Accident Md

15

Filed

Sept 30, 1914J. L. Richter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 13, 1914, to Sept 4, 1914,that I last saw him alive on Aug 30, 1914and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Hygostatic Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

diplegia(Duration) 5 yrs. 4 mos. ds.(Signed) C. R. W. Snyder, M. D.Sept 4, 1914. (Address) Accident Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Accident Md. Sept 6, 1914

20 UNDERTAKER

ADDRESS

Susan Engelhart Accident Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

9054

45

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

162

Village or City

Bettinger

(No. _____)

St.; _____

Ward) _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Christian J. Brummeman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Married

6 DATE OF BIRTH

March 6, 1847
(Month) (Day) (Year)

7 AGE

67 yrs. 6 mos. 16 ds.

If LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Jacob Brummeman

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Winterburg

(Address)

Grantville Md

15

Filed

, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 22, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 7th, 1914, to Sept 22, 1914.

that I last saw him alive on Sept 20, 1914

and that death occurred on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Bladder

(Duration) 1 yrs. 8 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

R. C. Bowen

, M. D.

Sept 24, 1914. (Address) Grantville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bettinger

Sept 24, 1914

20 UNDERTAKER

ADDRESS

Wm Winterburg Grantville Md.

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

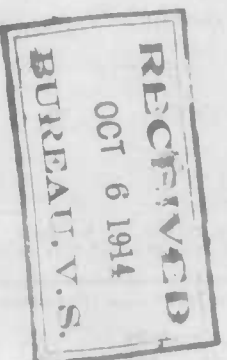
Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County Gauche 9055Village or City Gorman (No. 64) St. Ward STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Elizabeth Christensen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Feb 11th, 1841
(Month) (Day) (Year)

7 AGE 73 yrs. 6 mos. 24 ds. If LESS than 1 day,.....hrs. OR.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Jos. Friend
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Rachel Browning
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Christensen
(Address) Gorman, W. Va.

15 Filed Sept 8th, 1914 Norland L. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1914, to Aug 5, 1914, that I last saw her alive on Aug 5, 1914

and that death occurred on the date stated above, at 6 p. m.
The CAUSE OF DEATH* was as follows:

Asphyxia
(Duration) 2 yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Signed) H. W. McComas, M. D.
Sept 7, 1914 (Address) Danville, Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. to the State..... yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL On the farm DATE OF BURIAL Sept 8, 1914

20 UNDERTAKER D. E. Bolden ADDRESS Danville, Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

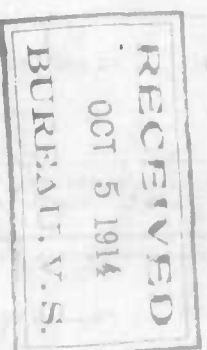
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 9056

County Garrett.Village or City Bloomington. (No. _____, St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 163.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Irene May Coffman.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married.
(Write the word)

6 DATE OF BIRTH July - 6th - 1914
(Month) (Day) (Year)

7 AGE 18 yrs. 4 mos. 15 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) N. Va.

10 NAME OF FATHER Isaac Cripp.
11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Maggie Allen.

13 BIRTHPLACE OF MOTHER (State or country) N. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Maggie Puckett(Address) Bloomington

15 Filed _____, 191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 21st., 1914.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17th., 1914. to Sept. 21st., 1914.
that I last saw him or alive on Sept. 21st., 1914.

and that death occurred on the date stated above, at 4 A.M. m.
The CAUSE OF DEATH* was as follows:

Eclampsia.(Duration) ____ yrs. ____ mos. 24 hrs.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Kemp., M. D.Address Bloomington, Md.

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18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington, Md. Sept 22., 1914.

20 UNDERTAKER

ADDRESS

H. R. Fred Cox Piedmont, W. Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

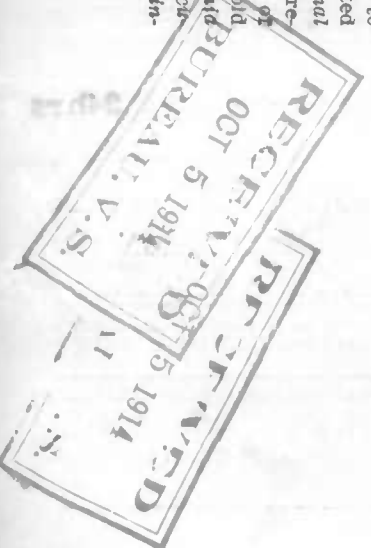
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1 PLACE OF DEATH *9447*
County *Germ. Md.*

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. *163*

Village or City *Vicinity of Farm Rock.* St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Harry Aslington Duckworth*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *10 26 1891*
(Month) (Day) (Year)

7 AGE *22 yrs. 11 mos. 1 ds.* 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment to which employed (or employer)

9 BIRTHPLACE (State or country)

PARENTS
10 NAME OF FATHER *Stephen A. Duckworth*
11 BIRTHPLACE OF FATHER (State or country) *Allegheny Co. Md.*
12 MAIDEN NAME OF MOTHER *Ida Warrick*
13 BIRTHPLACE OF MOTHER (State or country) *Allegheny Co. Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mother*
(Address) *Westernport, Md.*

15 Filed *9/28/1914* *Geo. L. Michaels*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 27th*, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 16th*, 1914, to *Sept 27th*, 1914, that I last saw him alive on *Sept 27th*, 1914,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Lymphoid fever.

(Duration) yrs. mos. ds.
Contributory (Secondary) *Perforated duodenum & typhoid*

(Duration) yrs. mos. ds.
(Signed) *Chas. L. Wilson*, M. D.
Oct 3rd, 1914 (Address) *Richmond, Va.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Michael's Cemetery* DATE OF BURIAL *9/28*, 1914

20 UNDERTAKER *W. H. Fredlock* ADDRESS *Richmond, Va.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

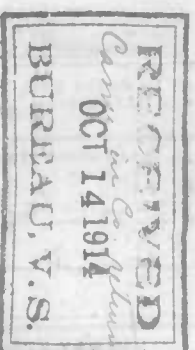
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Thantion," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Garrett 9057

(105)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 166Village or City Wheel Park (No. _____, St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Patrick Martin Griffin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH not known, 1865
(Month) (Day) (Year)

7 AGE 49 yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer on County place
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER James Griffin

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kennedy

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Griffin(Address) Wheel Park, Md.

15 Filed Sept. 14, 1914 Harland L. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9-11-1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him alive on 9-11-, 1914

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Suddenal death?

(Duration) about 10 min. yrs. _____ mos. _____ ds.

Contributory Hemorrhage by
Secondary ulcer perforating blood vessel

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edward C. Sullivan, M. D.

9-11-, 1914 (Address) Wheel Park, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Oakland DATE OF BURIAL Sept. 14, 1914

20 UNDERTAKER D. C. Boeden ADDRESS Oakland

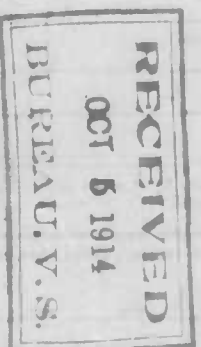
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faintly employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

9058

County

Garret

Village or City

Grand

(No. _____)

Registration Dist. No.

161

St; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ophelia Ann Grand

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

widow

6 DATE OF BIRTH

June 17, 1824
(Month) (Day) (Year)

7 AGE

90 yrs. 2 mos. 24 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Selbyport - Ind

10 NAME OF FATHER

Andrew Finnan

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Frouze

13 BIRTHPLACE OF MOTHER (State or country)

Selbyport Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Grand

(Address)

Grand Ind

15

Filed Sept 13th, 1914

Wm H Grand
Local

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Sept- 11, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 18, 1914, to Sept-11, 1914,
that I last saw her alive on July 18, 1914,

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Old age & Paralysis

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. J. Mason

M. D.

Sept-12th, 1914

(Address) Friendsville Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frouze Ridge, Cemetery

Sept 13th, 1914

20 UNDERTAKER

ADDRESS

O. Risherberger

Addison Pa

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

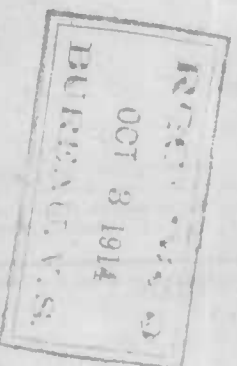
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH 9059

County GarrettVillage or City W. Lone Park No. 154FULL NAME Mary E. HouseSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH November 3rd, 1836
(Month) (Day) (Year)

7 AGE 77 yrs. 10 mos. 21 ds. If LESS than 1 day,.....hrs. OR.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) WVA

9 BIRTHPLACE (State or country) WVA

10 NAME OF FATHER John Vanhook

11 BIRTHPLACE OF FATHER (State or country) WVA

12 MAIDEN NAME OF MOTHER Sarah Linn

13 BIRTHPLACE OF MOTHER (State or country) WVA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee M. Bender

(Address) Markinsburg, WVA

15 Filed Sept 24, 1914 Wallaund L. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1914 to Sept 24, 1914

that I last saw her alive on Sept 22, 1914

and that death occurred on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

General Debility due to age
(Duration).....yrs.....mos.....ds.

Contributory (Secondary)

(Signed) M. C. Hurlburt M.D.
Sept 24, 1914 (Address) Oakland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Wallaund L. Jones

DATE OF BURIAL Sept 26, 1914

20 UNDERTAKER D. E. Bader

ADDRESS Oakland

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

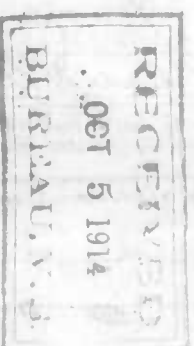
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Garrett 9060

Village or City Hoyes (No. 152)

2 FULL NAME

Alma Elizabeth Keller

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 164

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 12, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 4 ds. If LESS than 1 day, 13 hrs. OR 20 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9 BIRTHPLACE (State or country) Garrett Co Ind

10 NAME OF FATHER Joseph Keller

11 BIRTHPLACE OF FATHER (State or country) Garrett Co Ind

12 MAIDEN NAME OF MOTHER Elvia Cuckett

13 BIRTHPLACE OF MOTHER (State or country) Garrett Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. C. Andrew

(Address) Friendsville Ind

15 Filed Sept 20, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1914, to Sept 15, 1914.

that I last saw her alive on Sept 15, 1914.

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

unknown, the child was overly large at birth weighing 16 pounds and under pressure on the head caused the death

(Duration) 1 1/2 yrs. _____ mos. _____ ds.

Contributory (Secondary) Pressure on the head during birth

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Andrew M. D.

Sept 16, 1914. (Address) Friendsville Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 4 ds. In the State _____ yrs. _____ mos. 4 ds.

Where was disease contracted, at place of death

If not at place of death?

Former or usual residence usual

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hoyes Ind Sept 16, 1914

20 UNDERTAKER ADDRESS

S. Savage Friendsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

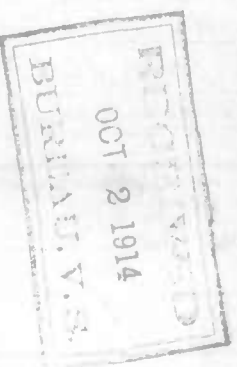
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Garnett 9061

Village or City Concord (No. 151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Balmy Rawlins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 19, 1914
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. If LESS than 1 day, 3 hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm Rawlins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Oliver Rose Phares

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Rawlins

(Address) Concord Md

15 Filed Sept 20, 1914 Concord Md
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1914 to Sept 19, 1914
that I last saw him alive on Sept 19, 1914

and that death occurred on the date stated above, at 1130 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia
Prone position
(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —

(Signed) D. L. Phares, M. D.
Sept 20, 1914 (Address) Concord Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Concord DATE OF BURIAL Sept 20, 1914

20 UNDERTAKER W. E. Balby ADDRESS Concord

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

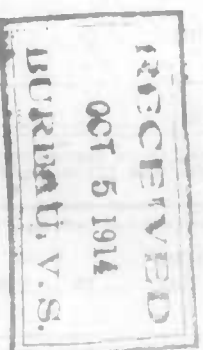
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not actually employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

9062

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Garnett

Registered No.

166

Village or City

Oakland

(No.)

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Julia C. Legge

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

AGE

72

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

OCCUPATION

(a) Trade, profession, or
particular kind of work

Housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE
(State or country)

Allegheny County

NAME OF FATHER

John Edwin Offutt

BIRTHPLACE
OF FATHER
(State or country)

Md.

MAIDEN NAME
OF MOTHER

Susan M. Lantz

BIRTHPLACE
OF MOTHER
(State or country)

Maryland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. E. Offutt

(Address)

Oakland, Md.

15

Filed

Sept. 17, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Sept.

15

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 10

1914

to

Sept. 14

1914

that I last saw her alive on Sept. 14, 1914

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Legg

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. W. M. Brown

M. D.

Sept. 17

1914

(Address)

Oakland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Oakland

DATE OF BURIAL

Sept. 17, 1914

20 UNDERTAKER

D. E. Bolger

ADDRESS

Oakland

If more blanks are needed, address State Registrar, 6 N. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

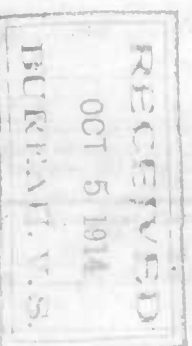
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

9063

County

Garrett

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 166

Village or City

Mt Lake Park

(No. _____)

St; _____

Ward) _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Gemmill McLain

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

November 7

(Month)

(Day)

1834

(Year)

7 AGE

79

yrs.

10

mos.

7

ds.

IF LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Druggist (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Ohio

PARENTS

10 NAME OF FATHER

John Gemmill McLain

11 BIRTHPLACE OF FATHER (State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Eliza Eleanor Baird

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Hay McLain

(Address)

Wheeling - W.Va

15

Filed

Sept. 15th, 1914

Harrison D. Jones

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 14

(Month)

(Day)

1914

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1914, to Sept-12, 1914.

that I last saw him alive on " 12, 1914.

and that death occurred on the date stated above, at 11³⁰ P.m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

H. W. McComas

M. D.

Sept-15, 1914 (Address)

Wheeling, W.Va

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

0 yrs.

3 mos.

2 ds.

In the

State

0 yrs.

3 mos.

2 ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

Wheeling - W.Va

19 PLACE OF BURIAL OR REMOVAL

Wheeling - W.Va

DATE OF BURIAL

September 17, 1914

20 UNDERTAKER

D. E. Bolden

ADDRESS

Wheeling, W.Va

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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RECEIVED
OCT 5 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Garrett

Village or City

Deer Park, R. D.

2 FULL NAME

Mac Donald

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

168

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH

Sept. 7, 1914
(Month) (Day) (Year)

7 AGE

It LESS than
1 day, hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

H. C. Mac Donald

11 BIRTHPLACE OF FATHER

(State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Bessie Sturm

13 BIRTHPLACE OF MOTHER

(State or country)

W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. C. Mac Donald

(Address)

Deer Park R. D.

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 7, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still-Born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

M. C. H. Humberg M. D.

191 (Address)

Oakland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garrett Co. Md. Sept 8, 1914

20 UNDERTAKER

ADDRESS

None

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

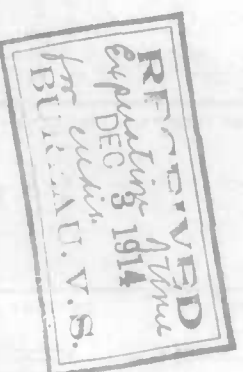
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

9064

Village or City

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

if LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed.....191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 10, 1914, 191
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 28, 1914, to Sept. 10, 1914, 191

that I last saw him alive on Sept. 10, 1914, 191

and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of the heart.

(Duration) 6 yrs. mos. ds.

Contributory (Secondary)

Chronic Brights

(Duration) 7 yrs. mos. ds.

(Signed)

1914 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monrovia Cemetery Sept. 12, 1914

20 UNDERTAKER

ADDRESS

John Winterberg Grantville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

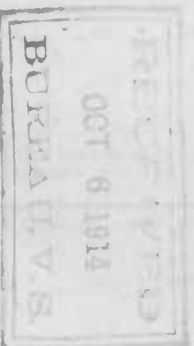
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(coal mining, etc.* Women at home, who are engaged in the duties of the household only (net paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal apoplexia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH
County Garnett 9065

Village or City Accident (No. 109) St. Ward

Registered No. 104

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Melchor J. Miller

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

⁶ DATE OF BIRTH November 17, 1833
(Month) (Day) (Year)

⁷ AGE 80 yrs. 9 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Germany
Kirsch-Hersdorff

¹⁰ NAME OF FATHER Philip Miller

¹¹ BIRTHPLACE OF FATHER (State or country) Germany
Kirsch-Hersdorff

¹² MAIDEN NAME OF MOTHER Maria D. Schneider

¹³ BIRTHPLACE OF MOTHER (State or country) Germany
Hackeburg-Hersdorff

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Miller

(Address) Accident Md

¹⁵ Filed Sep 30, 1914 J. B. Richter
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Sept 4, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from , 191 , to Sept 4, 1914

that I last saw him alive on Sept 4, 1914

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Subcutaneous Emphysema

(Duration) yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. W. Smyler, M. D.

Sept 5, 1914 (Address) Accident Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Accident Md Sep 7, 1914

²⁰ UNDERTAKER ADDRESS

Dusan Engelhart Accident Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic vesicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		STATE OF MARYLAND	
County <u>Gauche</u>		CERTIFICATE OF DEATH	
Village or City <u>St Rose Park</u> (No. <u>28</u>)		Registered No. <u>166</u>	
2 FULL NAME <u>John Robert O'Donnell</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Oct 13, 1884</u> (Month) (Day) (Year)			
7 AGE <u>29</u> yrs. <u>11</u> mos. <u>11</u> ds. OR <u>1</u> day <u>1</u> hrs. <u>1</u> min. ? If LESS than 1 day, hrs. min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Working Gauche P.R.</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Michael O'Donnell</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>W. Va.</u>		
	12 MAIDEN NAME OF MOTHER <u>McMahon</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. J.R. O'Donnell</u> (Address) <u>St Rose Park Md</u>			
15 FILED <u>Sept 25, 1914</u> <u>Halebury, J. Jones</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Sept 24, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug</u> , 1914, to <u>Sept</u> , 1914, that I last saw him alive on <u>Sept 12, 1914</u> , and that death occurred on the date stated above, at <u>8 4</u> m. The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds.			
Contributory (Secondary) <u>St. L. Broadwater</u> , M. D. (Signed) <u>Sept 25, 1914</u> (Address) <u>Carroll Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. In the State <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Carroll</u>		DATE OF BURIAL <u>Sept 25, 1914</u>	
20 UNDERTAKER <u>W.E. Balaban</u>		ADDRESS <u>Carroll</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*, *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tumult," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acidic*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECORDED
OCT 5 1914
BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Garrett</u>		9067	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Avilton</u>		(No. <u>64</u>)	Registration Dist. No. <u>178</u>	
2 FULL NAME <u>John Franklin Robeson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		
6 DATE OF BIRTH <u>January 9</u> , 18 <u>84</u> (Month) (Day) (Year)				
7 AGE <u>80</u> yrs. <u>7</u> mos. <u>27</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Former-retiree</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Wm Robeson</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Rodda Preston</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah Robeson</u> (Address) <u>Avilton Md</u>				
15 Filed <u>191</u>				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Sept 5</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> , to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred on the date stated above, at <u>9</u> a.m. The CAUSE OF DEATH* was as follows: <u>Not seen before death</u> <u>Cerebral hemorrhage with</u> <u>hemiplegia about</u> (Duration) <u>2</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory <u>—</u> Secondary <u>—</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>James A. Bullock</u> , M. D. <u>Sept 5</u> , 191 <u>4</u> . (Address) <u>Lonscarning</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>—</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Home farm</u>			DATE OF BURIAL <u>Sept 7</u> , 191 <u>4</u>	
20 UNDERTAKER <u>M. Eichhorn</u>			ADDRESS <u>Lonscarning</u>	
REGISTRAR If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. <u>Md</u>				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

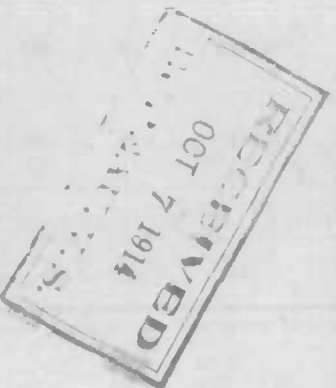
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Harriet 9068
County Harriet

Village or City Mt Zion (No. 40)

2 FULL NAME Elizabeth Sharpless

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 172

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St.; Ward)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 28, 1856
(Month) (Day) (Year)

7 AGE 58 yrs. 5 mos. 29 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Penna.

10 NAME OF FATHER Louis Fulmer

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Koch

13 BIRTHPLACE OF MOTHER (State or country) Penna.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. G. Barwick

(Address) Kelgumlers

15 Filed Sept 29, 1914 A. G. Barwick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1B DATE OF DEATH Sept 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1914, to Sept 26, 1914, that I last saw her alive on Sept 26, 1914

and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Jackson Welch, M. D.
Sept 28, 1914 (Address) Riverview Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

1B LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 28 mos. 4 ds. 22 In the State yrs. mos. 1 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

9 PLACE OF BURIAL OR REMOVAL Providence DATE OF BURIAL 29 Sep, 1914

20 UNDERTAKER Barwick & Co City miller ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

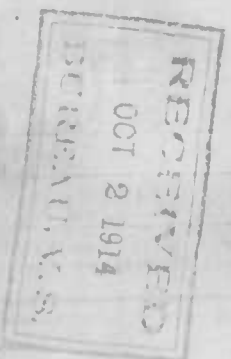
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary). *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <i>Garrett</i>		9069		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Garrett</i>				Registration Dist. No. <i>162</i>	
Village or City <i>Grantsville</i>		(No. <i>154</i>)		St. _____ Ward _____	
2 FULL NAME <i>Elizabeth Specker</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i> (Write the word)			
6 DATE OF BIRTH <i>June 29th, 1886</i> (Month) (Day) (Year)					
7 AGE <i>88</i> yrs. <i>7</i> mos. <i>23</i> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <i>Allegheny Co. Md.</i>					
PARENTS					
10 NAME OF FATHER <i>Do not know</i>					
11 BIRTHPLACE OF FATHER (State or country) <i>Do not know</i>					
12 MAIDEN NAME OF MOTHER <i>Do not know</i>					
13 BIRTHPLACE OF MOTHER (State or country) <i>Do not know</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Wm Winterting</i> (Address) <i>Grantsville</i>					
15 Filed _____, 191____ REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Sept 22</i> , 191 <i>4</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.					
that I last saw him _____ alive on _____, 191____.					
and that death occurred on the date stated above, at _____ m.					
The CAUSE OF DEATH* was as follows: <i>Old age.</i> <i>Had no doctor</i> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Signed) <i>Henry O. Baker</i> Registrar, M. D. <i>Sept 22</i> , 191____ (Address) <i>Grantsville, Md.</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <i>Maple Grove Cemetery</i> DATE OF BURIAL <i>Sept 25</i> , 191 <i>4</i>					
20 UNDERTAKER <i>Wm Winterting</i> ADDRESS <i>Grantsville, Md.</i>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

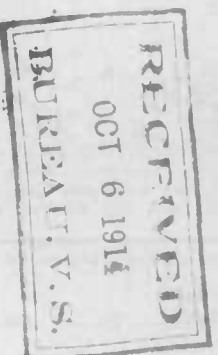
[Approved by U. S. Census and American Public Health Association.]

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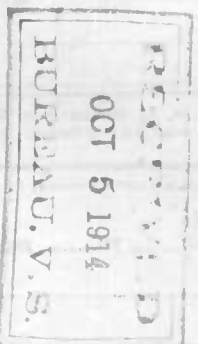
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1 PLACE OF DEATH 9071

County

Garrett

Village or City

Near Chaffer W. D.

(No.

St.; Ward)

Registered No.

172

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Silas E. Ditchenell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Sept 24, 1899

(Month)

(Day)

(Year)

7 AGE

15 yrs. 4 mos. 4 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Thomas W. Ditchenell

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Amanda Lewis

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Judson Miller

(Address)

1 Potomac Mills, Md.

15

Filed

Sept 28, 1914 A. G. Barnett

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 28, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 27, 1914 to Sept 27, 1914

that I last saw him alive on Sept 27, 1914

and that death occurred on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Enteric Fever

(Duration) yrs. mos. ds.

Contributory (Secondary)

Perforation - Collapse

(Duration) yrs. mos. ds.

(Signed)

S. Judson Miller, M. D.

Sept 28, 1914 (Address) Potomac Mills, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Teratta W. W. G. Sept 24, 1914

20 UNDERTAKER

ADDRESS

Barnick & Co Potomac Mills, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 2.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 2 1914
BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Garrett

9072

105

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 161

Village or City Friendsville (No. _____)

St: _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary J. Pettis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH March 2nd, 1835
(Month) (Day) (Year)

7 AGE 79 yrs. 6 mos. 19 ds. It LESS than 1 day/2 hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) General house work

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER John H. Halfe

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary J. Halfe

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Medrow
(Address) Friendsville Md

15 Filed Sept 22, 1914 Wm H. H. H. H. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1914, to Sept 21, 1914.

that I last saw him alive on Sept 20th, 1914.

and that death occurred on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

acute Enteritis

(Duration) yrs. mos. 11 ds.
Contributory (Secondary) Chronic Gastritis

(Duration) 3 yrs. 8 mos. — ds.
(Signed) W. C. Medrow, M. D.
Sept 21, 1914. (Address) Friendsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. 6 mos. — ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, at place of death

Former or usual residence usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blooming Rose Sept 22, 1914

20 UNDERTAKER ADDRESS S. Savage Friendsville

Original

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

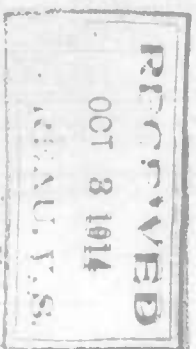
[Approved by U. S. Census and American Public Health
Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

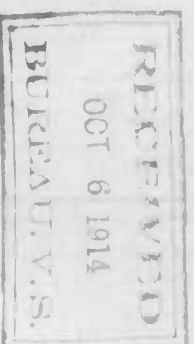
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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PLACE OF DEATH

9074

County

Garrett

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 166

Village or City

Oakland

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Anna Maria Weinge (Weinger)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

76

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)*Ireland*

PARENTS

10 NAME OF FATHER

*Pawn*11 BIRTHPLACE OF FATHER
(State or country)*Ireland*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER
(State or country)*Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Weinger

(Address)

Oakland Md

15

Filed *Sept 16th, 1911*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 16

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ P. M.

The CAUSE OF DEATH* was as follows:

*Found dead Natural Causes
Apoplexy*

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *M. L. Brickwater*, M. D.*Sept 16, 1911* (Address) *Oakland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Oakland

DATE OF BURIAL

Sept 17, 1911

20 UNDERTAKER

N. E. Beebe

ADDRESS

Oakland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

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RECEIVED

OCT 5 1914

BUREAU, V. S.

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1 PLACE OF DEATH
County Garrett

9075

79

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 162

Village or City New Germany (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Elijah Winters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 4, 1876
(Month) (Day) (Year)

7 AGE 38 yrs. 4 mos. 9 ds. OR LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) W. Va.

PARENTS
10 NAME OF FATHER John Lloyd Winters
11 BIRTHPLACE OF FATHER (State or country) W. Va.
12 MAIDEN NAME OF MOTHER Magdalena Snyder
13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John C. Winters
(Address) New Germany

15 Filed _____, 191____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 20th 1914, to Sept 13th 1914,

that I last saw him alive on Sept 13th 1914

and that death occurred on the date stated above, at 9:00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis
(Cardiac insufficiency)
(Duration) 15 yrs. _____ mos. _____ ds.

Contributory Acute Articular rheumatism
Secondary
(Duration) 15 yrs. _____ mos. _____ ds.

(Signed) R. C. Bowen, M. D.
Sept 14, 1914 (Address) Grantville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Griffiths Burying Ground DATE OF BURIAL Sept 15, 1914

20 UNDERTAKER J. M. Winters ADDRESS Grantville Md.

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